

# What is the Federally Required Disclosure Form (FRDF) for Individuals?

As required by 42 CFR § 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

- a) who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.
- b) what disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

(1)

(i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

(ii) Date of birth and Social Security Number (in the case of an individual).

(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

## How do I submit the FRDF?

**Upload** a completed/signed FRDF to the attachments panel on the POSC for enrollments initiated on the POSC.

**Mailed to:** MassHealth Provider Enrollment

P.O. Box 121205

Boston, MA 02112-1205

- **Tip:** All fields must be completed. Nothing should be left unanswered. If the section does not apply, check the box above the name field for the section.
- **Tip:** If addition space is needed, you must make a copy the appropriate page and attach each such copy to the signed form. All entries must be submitted using this form.

## How to complete the FRDF

### Review FRDF: Page 1, Section 1

Enter the legal information for the provider. Note the legal address must be their home address.

SECTION 1: PRACTITIONER INFORMATION														
Legal Name of Practitioner: Last										First			Middle Initial	
Date of Birth			National Provider Identifier Number (NPI)							SSN				
Home Street Address														
City								State		Zip				
Tel. #								Fax #						
E-mail														
Preferred Contact Name (if different than above)														
Preferred Contact E-mail (if different than above)														
Tel. #														

Enter the primary address where the provider practices.

SECTION 2: PRIMARY SERVICE LOCATION (PSL) INFORMATION														
DBA Name (Primarily applies to individuals who are sole proprietors and NOT to entities separately completing PE-FRD)														
<input type="checkbox"/> NONE														
Is PSL address same as home address in Section 1? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, practitioner need not complete remainder of Section 2.														
PSL Street Address (street address only; P.O. Boxes are not acceptable)														
City								State		Zip				
Tel. #								Fax #						
E-mail														

## Review FRDF: Page 2, Section 3

Enter the information for individual and entities related to the practitioner as described. Include all applicable information.

If you need additional space, copy this page and indicate the page numbers on the bottom right.

### SECTION 3: INDIVIDUALS AND ENTITIES RELATED TO PRACTITIONER

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

List any individual or entity with which the practitioner has one or more of the relationships described below, whether such relationship is defined by the practitioner's relationship to or interest in the other party, or by the other party's relationship to or interest in the practitioner (e.g., list entities in which the practitioner is a managing employee, AND managing employees of the practitioner). Although unusual, check "NONE" if none.

- i. Has a direct or indirect ownership interest (or any combination thereof) of five percent or more in the applicant;
- ii. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the applicant or any of the property assets thereof, in which whole or part interest is equal to or exceeds five percent of the total property and assets of the applicant;
- iii. Is an officer or director of the applicant, if the applicant is organized as a corporation;
- iv. Is partner in the applicant, if the applicant is organized as a partnership;
- v. Is an agent of the applicant;
- vi. Is a managing employee—that is, an individual (including a general manager, business manager, administrator, or director) who exercises operational or managerial control over the applicant or part thereof, or directly or indirectly conducts the day-to-day operations of the applicant or part thereof; or
- vii. Was formerly described in i through vi of this section, but is no longer so described, because of a transfer of ownership or control interest to an immediate family member or a member of the person's household in anticipation of or following a conviction, assessment of a civil money penalty, or imposition of an exclusion.

The definitions applicable to this section are as follows:

- *Agent* means any person who has express or implied authority to obligate or act on behalf of another party (e.g., office manager, billing agent, group practice organization).
- *Immediate family member* means a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild.
- *Indirect ownership interest* includes an ownership interest through any other entities that ultimately have an ownership interest in the applicant (e.g., an individual has a 10 percent ownership interest in the applicant if he or she has a 20 percent ownership interest in a corporation that wholly owns a subsidiary that is a 50 percent owner of the applicant).
- *Member of household* means, with respect to a person, any individual with whom he or she is sharing a common abode as part of a single family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.
- *Ownership interest* means an interest in:
  - the capital, the stock, or the profits of the applicant; or
  - any mortgage, deed, trust, or note, or other obligation secured in whole or in part by the property or assets of the applicant.

☐ NONE (if NONE continue to Section 4) ☐ Ownership/Controlling Interest (of 5% or more)\* ☐ Managing Employee\* ☐ Agent\*

Name of Individual (Last, First, Middle Initial) or Entity

NPI

% of Ownership (if 5% or more)

Title, Function, or Relationship to Practitioner

Address (Home Address if Individual; Business Address if Entity)

City

State

Zip

—

SSN (if Individual)

Date of Birth

EIN (if Entity)

\*For definition and further explanation of these terms, please see the top of Section 3 above.

PLEASE MAKE A COPY OF THIS PAGE IF YOU NEED TO LIST MORE THAN THREE INDIVIDUALS OR ENTITIES OR ADDITIONAL ADDRESSES. NUMBER  OF   
(All business, corporate, and P.O. boxes must be listed.)

Please attach each such copy to the signed form. Please refer to all attached pages when answering the disclosure questions in Section 4.

## Review FRDF: Page 3, Section 4A

Answer each of the disclosure questions. If any are answered Yes, provide a detailed explanation on the next page.

### SECTION 4: DISCLOSURES

For additional information, see 42 CFR § 455.106, 455.436, and §1002.3, and 130 CMR 450.212.

#### 4A. DISCLOSURE INFORMATION

Respond to the following questions on behalf of the practitioner AND any individuals/entities identified in Section 3 (except for question 5, where your response may be limited to the practitioner). If you answer "yes" to any question, provide a detailed explanation in Section 4B, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number.

1. Have any of the individuals/entities ever been convicted of a criminal offense related to any program under Medicare, Medicaid, or Title XX services?  
☐ Yes ☐ No
2. Have any of the individuals/entities been convicted of a criminal offense as described in sections 1128(a) and 1128(b) (1), (2), or (3) of the Social Security Act?  
☐ Yes ☐ No
3. Have any of the individuals/entities been excluded from participation in any federal or state health program (including, but not limited to, Medicare or Medicaid)?  
☐ Yes ☐ No
4. Have any of the individuals/entities had civil money penalties or assessments imposed under section 1128A of the Social Security Act?  
☐ Yes ☐ No
5. Has the practitioner ever been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities?  
☐ Yes ☐ No
6. Is there currently pending any proceeding(s) that could result in a conviction, sanction, or other action reportable in questions 1 – 5, above?  
☐ Yes ☐ No

## Review FRDF: Page 4, Section 4B

If any of the questions in Section 4A were answered Yes, provide a detailed explanation.

#### 4B. ADDITIONAL EXPLANATION

If you answered "yes" to any question in Section 4A, you must provide a detailed explanation below, including the name of the individual/entity; nature, date, and forum of the action; and any case or record number. Attach additional pages if necessary.

Review the FRDF: Page 4, Section 5

The form must be signed by the provider.

### **SECTION 5: CERTIFICATION STATEMENT**

#### **PLEASE READ CAREFULLY AND SIGN**

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

\_\_\_\_\_  
Printed Legal Name of Practitioner

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Note: Signature or date stamps, electronically generated signatures or dates, or the signature of anyone other than the practitioner are not acceptable.

**Print**

**Clear**

Mail the completed form to this address.

Return your completed form to [providersupport@mahealth.net](mailto:providersupport@mahealth.net) or mail to the following:

**MassHealth Customer Service Center**  
Attn: Provider Enrollment and Credentialing  
P.O. Box 121205  
Boston MA 02112-1205

If you have questions about or need assistance with the completion of this form, please e-mail the MassHealth Customer Service Center at [providersupport@mahealth.net](mailto:providersupport@mahealth.net) or call 1-800-841-2900.